STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	17E256	A. BUILDING _____ B. WING _____	04/10/2013

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
BRIGHTON PLACE NORTH	1301 NE JEFFERSON ST. TOPEKA, KS 66608

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F 000	INITIAL COMMENTS The following citations represent the findings of a Health Resurvey. A revised copy of the 2567 was sent to the facility on 4/18/13.	F 000		
F 157 SS=D	483.10(b)(11) NOTIFY OF CHANGES (INJURY/DECLINE/ROOM, ETC) A facility must immediately inform the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interested family member when there is an accident involving the resident which results in injury and has the potential for requiring physician intervention; a significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life threatening conditions or clinical complications); a need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or a decision to transfer or discharge the resident from the facility as specified in §483.12(a). The facility must also promptly notify the resident and, if known, the resident's legal representative or interested family member when there is a change in room or roommate assignment as specified in §483.15(e)(2); or a change in resident rights under Federal or State law or regulations as specified in paragraph (b)(1) of this section. The facility must record and periodically update the address and phone number of the resident's	F 157		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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F 157	Continued From page 1 legal representative or interested family member. This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 11 residents, of which 10 were reviewed for unnecessary drugs. Based on observation, record review and interview the facility failed to notify the physician in a timely manner as ordered for blood pressures that were outside of the parameters for 2 of 11 sampled residents. (#5, #25) Findings included: - Resident #5's annual (MDS) Minimum Data Set 3.0 assessment, dated 12/30/12, indicated the resident was cognitively intact with a (BIMS) Brief Interview for Mental Status score of 13 and the resident was independent with (ADLs) Activities of Daily Living. The 4/4/13 care plan directed the staff to administer medications, report results, and follow up as ordered by the physician. The 3/20/13 (POS) Physician Order Sheet and the physician's Standing Orders, dated 8/7/12, directed the staff to recheck the resident's blood pressure if it was lower than 90/60 or higher than 160/90 and if the blood pressure continued to be outside of the parameters, to call the physician. The physician's order, initiated 4/6/2005, directed the staff to administer Enalapril (a blood pressure medication), 2.5 (mg) milligram, by mouth every day to the resident.	F 157		

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Review of the (MAR) Medication Administration Record, revealed the staff did not administer Enalapril on a daily basis from November 6, 2012 through December 17, 2012 as ordered by the physician.

The 12/17/12 physician progress note indicated the nursing staff notified the physician of the resident's consistently low blood pressures and the physician replied, the resident is to be taking Enalapril daily, he/she is on a very low dose and it was for kidney protection.

Review of the 2013 blood pressure records revealed the following:

1) January- the blood pressure was under the parameters 21 times. On 1/1/13 the resident's blood pressure was documented as 80/30. On 1/27/13 the record indicated a blood pressure of 72/49 and no notes regarding recheck of the blood pressure or assessment of the resident.

2) February- the blood pressure was under the parameters 21 times. On 2/17/13 and 2/18/13 the resident's blood pressure was 80/40.

3) March - the blood pressure was under the parameters 19 times. One of the days, the resident's blood pressure was 79/54.

Review of the medical record and nurse's notes revealed the staff did not recheck the low blood pressure, re-assess the resident or notify the physician of the low blood pressures.

On 4/8/13 at 8:20 AM, observation revealed the

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resident seated in the living room area, appropriately dressed and groomed.

On 4/9/13 at 1:10 PM, Nurse A stated in December the staff held the Enalapril numerous times because of low blood pressure. Nurse A verified the physician's orders did not direct the staff to hold the medication, just to notify the physician, and the staff did not do either for the resident's low blood pressures as directed by the current physician orders.

The facility's 4/9/13 Blood Pressure Monitoring policy indicated the staff were to obtain residents' blood pressure at least weekly or more often as indicated by individual physician orders. The results will be monitored by the charge nurse obtaining the blood pressure and if any blood pressure is outside the parameters written by the physician or on the standing orders, the blood pressure will be rechecked one time. If the blood pressure continued to be outside of the parameters, the staff shall notify the physician. All blood pressure results will be documented on the resident's individual flow sheets.

The facility failed to notify the physician when this resident's blood pressure was outside of the parameters on multiple occasions.

- Resident #25's quarterly (MDS) Minimum Data Set 3.0 assessment, dated 12/6/12, indicated the resident was cognitively intact.

The 3/14/13 care plan directed the staff to administer all medications as physician ordered and observe for side effects. The care plan directed the staff to notify the physician

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immediately if the resident was having adverse side effects.

The physician's Standing Orders initiated on 8/7/12, directed the staff to recheck the resident's blood pressure if it was lower than 90/60 or higher than 160/90 and if it continued to be outside of the parameters, call the physician.

Review of the medical record revealed the following:

1) January 2013- the resident's blood pressure was under the physician ordered parameters 17 times.

2) February 2013- the resident's blood pressure was under the physician ordered parameters 17 times and as low as 70/46.

3) March 2013- the resident's blood pressure was under the physician ordered parameters 6 times and as low as 70/48.

Review of the medical record and nurse's notes revealed no recheck of the low blood pressure, no assessment of the resident or notification of the physician.

On 4/8/13 at 11:20 AM, observation revealed the resident ambulated around the halls, lobby and living room of the facility.

On 4/9/13 at 9:23 AM, Nurse A stated the staff were to notify the physician regarding the low blood pressures and recheck the blood pressure if it was below the physician ordered parameters. Nurse A stated the physician ordered the blood

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F 157	Continued From page 5 pressures obtained daily in November 2012, after the resident had some low blood pressures. The facility's 4/9/13 Blood Pressure Monitoring policy indicated the staff were to obtain residents' blood pressure at least weekly or more often as indicated by individual physician orders. The results will be monitored by the charge nurse obtaining the blood pressure and if any blood pressure is outside the parameters written by the physician or on the standing orders, the blood pressure will be rechecked one time. If the blood pressure continued to be outside of the parameters, the staff shall notify the physician. All blood pressure results will be documented on the resident's individual flow sheets. The facility failed to notify the physician when the resident's blood pressure was below the parameters on multiple occasions.	F 157		
F 371 SS=F	483.35(i) FOOD PROCURE, STORE/PREPARE/SERVE - SANITARY The facility must - (1) Procure food from sources approved or considered satisfactory by Federal, State or local authorities; and (2) Store, prepare, distribute and serve food under sanitary conditions This REQUIREMENT is not met as evidenced by: The facility had a census of 34 residents. The sample included 11 residents. Based on	F 371		

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observation, record review and interview the facility failed to provide a clean, sanitary environment to prepare meals for the 34 residents who received meals from the facility's kitchen.

Findings included:

- On 4/8/13 at 12:25 PM, observation in the kitchen revealed 2 of 3 overhead fluorescent lights in the kitchen had visible dead bugs inside the covers. Further observation revealed the inside of the ice machine had a small amount of black, moldy looking spots on the water pipe at the back of the ice chamber.
On 4/8/13 at 12:25 PM, Dietary Staff A verified the observation and stated staff were to clean the ice machine twice monthly, but he/she had no documentation as to when the ice machine was last cleaned. Dietary staff A stated he/she had not observed the black spots, which looked like mold, on the piping inside the machine when he/she cleaned it a couple of weeks ago.

The undated Dietary Services Cleaning policy directed the staff to establish and follow cleaning schedule procedures to ensure that all equipment and work areas, including walls, floors, ice machines, and ceilings are cleaned routinely. The Dietary Cleaning Schedule attached indicated the ice machine was to be cleaned on Saturdays.

The facility failed to ensure a clean, sanitary environment for the preparation of meals for the 34 residents of the facility.